Child and Adolescent Health Centers
Frequently Asked Questions - Clinical Model

Minimum Program Requirements (MPR's)

Q: The philosophy of the CAHC Program's clinical model is that the health centers act as the primary care provider for the day to any youth who seeks service. What does this mean?

A: The purpose of the Child & Adolescent health centers is to provide clients with a broad spectrum of health care, both preventive and curative (including assessment, diagnosis and treatment), over a period time and to coordinate that care to the extent possible. Clinicians should be addressing a broad range of personal health care needs, diagnosing and treating illness and injury, providing health promotion and education with an emphasis on prevention and developing sustained relationships with clients. Assessment of risk is essential. Services to inform clinical decision making (such as ordering labs and diagnostic testing) are expected. The clinical health centers should not be viewed or run as school nursing or urgent care clinics. Referral to specialists as appropriate is anticipated. Follow-up is critical to providing quality care. Communication and coordination with an "assigned" primary care physician is desirable and encouraged for critical issues and to the extent feasible for more routine health care issues. We do not expect to see referral back to the primary care provider for services that could be handled at the health center (e.g., immunizations, physical exams to name a few).

When a client comes to the health center, you should provide the services that you would expect to provide as the client's primary care provider. Keep in mind that the majority of clients do not seek care at their "assigned" primary care provider's office and the health center often is the regular source of primary care for clients. Adolescents, in particular, are the population least likely to seek and receive routine medical care from a physician's office, so your center should take advantage of every opportunity to provide a comprehensive set of medical services to its clients.

Q: MPR #10 (adolescent centers) / MPR #9 (elementary centers) states that "the health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year

when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation." Is there any leeway on this requirement?

A: The expectation is that your center will be accessible to students throughout the year, the same as an ordinary primary care office. While the number of students accessing school-based centers may diminish during times when school is not in session, clients still need access to care. This access is particularly crucial to the numerous students who use the center as their main or only source of health care and those who are seen for chronic conditions and mental health counseling. While the client flow may be lessened during school breaks, staff can take advantage of this relaxed pace to continue to see clients, make appointments, refill prescriptions, conduct follow-up, administrative and evaluation activities (e.g., review and tabulate needs assessments, client satisfaction surveys, chart reviews, research programming, write work plans, etc.).

If there are times when the school building is absolutely inaccessible (e.g., closed two weeks in the summer because of intensive extermination activities, three weeks for extensive reconstruction, etc.) then you should notify MDCH in writing immediately to negotiate an acceptable period of closure and plans for providing back-up coverage.

Additionally, the clinical provider should try to plan vacations around the school schedule as much as possible. There should be a plan for coverage any time the center is forced to close so that clients still have access to routine care.

Q: MPR #10 (adolescent centers) / MPR #9 (elementary centers) requires that clinical services be available 30 hours per week. What should I do if my main clinical provider leaves for some reason (e.g., resigns, takes medical leave, etc.)?

A: You must notify MDCH in writing within 10 days regarding any extended lapse or significant change in staffing that leaves the health center unable to deliver clinical services 30 hours per week with the main clinical provider. In this notification, you should also include a timeline for filling the vacancy and a plan for interim clinical staffing of the health center. You must also notify MDCH in writing when the vacancy is filled and provide the name and complete contact information for any new clinical provider.

Q: MPR #12 (adolescent centers) / MPR #11 (elementary centers) indicate that the health center (if staffed by a nurse practitioner)

has to be staffed by a FNP, PNP or SNP. Why is staffing limited to only nurse practitioners with those credentials?

A: Clinical providers must have the appropriate knowledge and experience with children and adolescents to practice in a state-funded health center, therefore nurse practitioners are required to have the appropriate credentials in one of these three specialty areas. Nurse practitioners without these credentials are working outside of their scope of practice. As one example, a nurse practitioner within a different specialty area, e.g., women's health, would be working outside of his/her specialty area and scope of practice if working with children in an elementary center. This increases potential for liability. Physician assistants should also have significant pediatrics experience, which is explicitly required in the elementary minimum program requirements.

Q: MPR #13 states that the health center's quality improvement plans includes "peer review." What is "peer review" and why is it required?

A: Peer review is a process used for checking the work performed by one's equals (peers) to ensure it meets specific standards. Peer review is used in many professions based on the philosophy that peers can identify each other's errors quickly and easily, expediting the time that it takes for mistakes to be identified and corrected. The purpose of peer review is to verify whether the work satisfies the specifications for review, identify any deviations from the standards, and provide suggestions for improvement. (Thanks to WhatIs.com for that succinct definition!) For a nurse practitioner, this would mean another nurse practitioner reviews the work; for a physician's assistant, another physician's assistant conducts the review. A review of a nurse practitioner or physician assistant's work (e.g., charts) conducted by a physician does *not* qualify as peer review.

In school-based and school-linked health centers, where clinicians often work in relative isolation, peer review is not only critical, but beneficial, in verifying conformity with standards of care, scope of practice issues and for identifying areas for improvement. It is essential for clinicians to have the type of review and feedback that can only come from one's peers, which is why a peer review process is required.

If your main clinician needs a "peer" to conduct a peer review process, you can contact MDCH to facilitate peer review with a clinician from another state-funded health center.

Q: MPR #13 indicates that our health center must conduct or access a health needs assessment every two to three years to determine needs of the population. Can we just use the Michigan-YRBS as our needs assessment?

A: The Youth Risk Behavior Survey (YRBS), organized by the Center for Disease Control and administered in Michigan by the Michigan Department of Education, is generally not approved as the sole source of health/needs assessment data for any center. It can be used as part of the overall needs assessment process, but should not be considered as the only source of health risk behavior data for your student population.

The Michigan-YRBS is conducted with a sample of schools and the school with which you work most likely does not participate. While the results of the YRBS can usually be generalized to the larger adolescent population, there may be some distinct differences or unique needs among the population with which you work. One of the best ways to draw out such nuances is to conduct a health/needs assessment survey with that population specifically. Each center is required to conduct a health/needs assessment survey every two to three years, so permission to use the YRBS as the health needs assessment survey is granted in *very rare* circumstances e.g., to a school-linked center that serves many different schools or to a school that can verify participation in the YRBS (Michigan or Detroit-specific). Even then, those health centers are strongly encouraged to gather other sources of data specific to the school population(s) they serve.

Q: MPR #14 requires the local community advisory council (CAC) approve four specific policies. Why does this policy exist when an outside body can't approve or change policies governed by our sponsoring agency?

A: The community advisory councils are a major source of support for the health center. In fact, they are viewed as so integral to the health centers that the Michigan Legislature requires each center to have an operational community advisory council and stipulates some membership and operational requirements, including one-third parent member composition.

The four policies (parental consent, confidential services, request for medical records and release of information and reporting of child abuse and neglect) which are required to be approved by the community advisory council are those that are often the most controversial and/or misunderstood. It is imperative that the community advisory councils are

familiar with the policies, their purpose and their relationship to Michigan law and that the council's endorsement of these policies is documented. In the event of any violation or challenge to one of these policies, the community advisory council would no doubt be one of the first entities that would be looked to in terms of response or action. An uninformed council which did not approve the policies will not be able to support the center or the client.

Q: MPR #18 states that the health center must provide services to youth regardless of their ability to pay. If a client refuses to pay, can we turn the responsible financial party over to collections?

A: Your center should not turn any client or client's family over to internal collections or to an external collection agency for unpaid bills. This would be damaging to client-center relations and inhibit youth from continuing to seek services at the center (barrier to care). The funding that is provided through this program is intended to off-set the costs for services that are unpaid for any reason e.g., rejected or not covered by an insurance plan or client can not/does not pay.

If your sponsoring agency's policy is turn over to collections any unpaid balances, be advised that this - and sometimes other sponsoring agency policies - do not fit well with the child and adolescent health center model and usually separate policies and procedures must be written that are specifically applicable to the health center operations.

Q: Why are the elementary health centers required to have a half-time mental health provider on staff but the adolescent health centers are not?

A: Mental health is recognized as a significant need at both the elementary and adolescent levels of care. At the time the elementary center model was added to the CAHC program, the requirement of a half-time mental health provider was included with the newly-developed elementary minimum program requirements as this would not be adding an unfunded mandate to these centers. If this had been added to the existing minimum program requirements for adolescent centers, there would not have been additional or sufficient state funding to support this additional requirement. Such an unfunded mandate was viewed as unfair to the adolescent health centers which have the added responsibility of providing reproductive health services.

MDE, MDCH and the School/Community Health Alliance of Michigan, Michigan's CAHC provider organization, work together to find avenues to

increase the availability of mental health service provision in the adolescent health centers. At some point in time, when enough centers have stabilized funding to provide a minimum level of mental health services, this may become a requirement for the adolescent health centers as well. At this time, however, adolescent centers are strongly encouraged to find additional funding support to provide an adequate level of much-needed mental health services to their clients.

Performance-Based Contracts

Q: Child & Adolescent Health Centers recently moved to "performance-based contracts." What does this mean and how does it affect my health center?

A: Performance-based contracts involve measuring contractor (health center) performance for the purpose of determining the proportion of the total contract amount paid to a health center in terms of the attainment of a performance output measure. **The performance output measure is the total number of unduplicated clients served in one year**. In effect, health center performance is measured against the achievement of the performance output measure (number of unduplicated clients served). If satisfactory achievement of the performance output measure is not realized, a reduction will be made in the total contract amount for the subsequent year.

Fiscal Year 2006 was the first year for performance-based contracting for the health centers, meaning this was the first year that health centers had to project a specific performance output measure/number of unduplicated clients to be served. Because this was a new concept to the health centers, no financial reductions in contracts were issued in Fiscal Year 2007 based on the previous year's performance. In future years, centers who fail to reach at least 90% of the projected performance output measure will see a proportionate reduction in the amount of subsequent year contracts. In year five of the five-year funding cycle, centers will either have the last payment withheld and reductions taken out of the last payment; or will be required to repay the amount of the contract reduction.

Q: Who determines the performance output measure?

A: The health center, together with its sponsoring agency, projects an annual performance output measure and proposes this to MDCH by submitting it along with the contract each fiscal year. The performance output measure should be based on factors including a review of previous

unduplicated user numbers and population size in the school/community where the center is located. MDCH reviews the proposed, projected performance output measure and will re-negotiate a new measure if the number proposed by the health center/sponsoring agency is viewed as unreasonably high or low based on the aforementioned factors.

Q: Does the output performance measure include youth who participate in support services or health education programming?

A: No. The output performance measure only includes the number of unduplicated users (clients) of the center.

Q: Can my health center serve youth outside of the target age range for which it receives state funding? What about serving adults?

If you have supplemental funding, your center can serve youth outside of the target age range for which it was funded. State funding should be focused on staffing and services geared to your target population.

Note that only the youth within the target age range for the model funded (elementary or adolescent) will count toward the unduplicated user number / performance output measure. With that in mind, the majority of your clients should fall within the age range for which the center receives funding. For example, if your center is an elementary site, the majority of youth served should be those between the ages of five and 10 and only those individuals will count toward the unduplicated user number / performance output measure. You can still provide services to adolescents (e.g., siblings of your elementary clients, students at a nearby middle school) and report them to MDCH but they won't count toward the unduplicated user number or performance output measure.

If you have a school based health center and you can fulfill the minimum program requirements of both the elementary and adolescent models, you may request designation from MDCH to count clients in both age ranges toward your unduplicated user number and performance output measure. Regardless of the special designation, your center should have a clear focus on either the elementary or adolescent population.

Adults should be served at separate hours from youth to protect the integrity of the health center model as well as youth confidentiality. Other funding must clearly support the staff and operations of service provision to adults as anyone over age 21 falls outside the age range served by the adolescent health center model.

Mandatory Focus Areas and Research-Based Interventions

Q: How were the six mandatory focus areas determined?

A: The six mandatory focus areas were determined mutually by the Michigan Departments of Education and Community Health in response to the number of requests from other state agencies, legislators and the public as to what the departments/health centers were doing to impact these issues. These focus areas are: teen pregnancy prevention, HIV/sexually transmitted infection prevention, tobacco prevention/ cessation, obesity prevention/management (includes nutrition and physical activity), asthma and mental health. These are health issues of concern in the child/adolescent population and health centers can reasonably be expected to make an impact in these areas through clinical services, support services and health education programming.

Q: What is my health center expected to do to address these focus areas?

A: Every year, each health center is required to develop programming/ interventions in a minimum of two of the six mandatory focus areas; and many centers opt to concentrate on more than just two focus areas. In the health center's annual work plan, the focus areas selected must be identified and include an overall goal, measurable outcome objectives with evaluation methods and research-based and/or promising programming/interventions. For centers providing clinical services, the programming/interventions can include a mix of evidence-based clinical approaches and support services and/or health education interventions. Support services and health education can be individual or group-based programs. Each focus area should have at least two to three distinct programs/interventions identified to be considered an area of focus. Clinical activities that are incorporated into the center's standards of care can be included as an intervention in the focus area, but can not be the only activity in the focus area. Additionally, your center can include other types of activities in the work plan (e.g., assemblies, one-time presentations) to supplement the research-based and promising interventions, but these types of activities are not expected to have a significant or lasting impact on knowledge, attitudes or behaviors so they alone would not meet the criteria for addressing the mandatory focus areas.

Q: State-funded health centers are required to use "research-based" or "promising" programming and/or interventions in the

work plans to address the six mandatory focus areas. How are "research-based" and "promising" defined? Why does this requirement exist?

A: Research-based programs (also known as evidence-based programs) are those which have been shown through rigorous evaluation design to be effective in significantly impacting specific health outcomes and/or risk behaviors among the population to which the program was delivered. These programs generally have been replicated in multiple populations or locations with similar effects. The results of an empirical evaluation design, demonstrating significant effectiveness, are typically published in the literature (e.g., peer-reviewed journals), reviewed by independent scientific review panels, and are recognized by nationally respected organizations and/or government agencies.

Similarly, promising programs (sometimes also called "best practice") are those that, through a smaller body of research, are proving to be reliable or showing promise in achieving a desired outcome. These are emerging programs or interventions that show promise in consistently producing evidence that they work, but the outcomes may not be as widely tested or documented as those considered to be "research-based."

Evidence-based clinical services and guidelines are also widely available. For example, the Guide to Clinical Preventive Services, published by the U.S. Preventive Services Task Force, identifies recommendations for preventive clinical care based on the latest scientific evidence. The Cochrane Collaboration is another resource that reviews clinical studies and publishes recommended standards of care that your center can incorporate into clinical practice and measure through chart reviews and other methodology.

Numerous entities publish compendia of research-based and promising programs and interventions (including clinical interventions) depending on the health issue or risk behaviors addressed. Some compendia may use research or evidence-based and promising or best practice terminology interchangeably, so be sure to look at the criteria for inclusion in whatever resource you are using to identify programs/interventions.

This requirement exists to ensure the greatest impact of programming and clinical care for youth, and maximum impact of the dollars used to support the CAHC Program. Policy makers increasingly request to see outcome evaluation results and the best way to ensure good outcome evaluation is to use research-based programming.

Q: Does MDE or MDCH have a list of approved "research-based" or "promising" programs/interventions?

A: Neither agency maintains a single, exhaustive list of programs or interventions that a health center could use. MDCH does maintain a list of programs that have been approved for use in the health centers, but this list is not exhaustive. *You can request a copy of this list by contacting your assigned MDCH State Consultant*. There are myriad resources available for identifying programs and interventions appropriate for your youth population through government, university, private and non-profit entities. Your health center staff should carefully review needs assessment and services data to determine the needs of your target population, and then research the options best-suited to address those needs.

Reporting

Q: Why are some reports collected on the state fiscal year (October 1 to September 30) and other reports collected on the calendar year?

A: The narrative progress report on the work plan, financial status report (FSR) and Medicaid outreach coincide directly to the state fiscal year of October 1 – September 30. The Request for Proposal and renewal applications must be issued on the fiscal year cycle. Therefore, contracts, progress reports, Medicaid outreach reports and budgetary information tied to the applications must also run on this fiscal year which is why these reports must correspond to this time frame.

The Michigan Legislature requires that the data, health education and billing reports be collected and reported to the Legislature on the calendar year.

(Remember that because you submit the Medicaid outreach data by quarter, MDCH reconciles the year-to-date data on the fiscal year – this is not something your health center is required to do any longer.)

Q: How do I count unduplicated users of the health center?

A: A clinical health user is an individual who has presented themselves to the center for service with the main clinical provider (Nurse Practitioner, Physician Assistant or Physician) or the main mental health provider (minimum Master's prepared and licensed mental health provider) and for whom a record/chart has been opened.

Once per calendar year, each user is counted once to generate the unduplicated count of clients utilizing the center services for that calendar year. When a new calendar year starts on January 1, each individual user who receives services at the center (according to the above definition) is counted once as an unduplicated user for the current calendar year regardless of whether he or she was counted as a user in the previous calendar year or not.

Once an unduplicated user is counted for the calendar year, he or she is never counted again during that calendar year as an unduplicated user. The number of unduplicated users tends to fluctuate by quarter, with higher numbers of unduplicated users expected in the first and third quarters (e.g. beginning of the new year and start of the school year). Visits and services received by unduplicated users continue to accumulate and are reported each quarter.

Note that the unduplicated user number refers only to those youth who have seen the main clinician or mental health provider for a documented visit. Those youth who attend health education presentations but never access the clinic services are not considered unduplicated users of the center. They are, however, counted in the health education presentation form.

Q: How are the quarterly data reporting elements used?

A: The quarterly data reporting elements are compiled annually (on the calendar year) and incorporated into a mandated report to the Michigan Legislature. The reports also provide valuable information to the MDCH staff as to the client load and productivity of the health centers, and as to emerging health needs of youth who access the centers.

Q: The billing report requires that our health center report the number and percent of claims paid out of the total number submitted. Why is this information necessary?

A: The data on the number and percent of claims paid out of the total submitted helps MDCH identify potential problems such as health plans that are not reimbursing well, centers that are not submitting claims properly, or centers that are submitting claims for an inordinately high level of non-billable services. This information would not be as readily evident if only the dollar amount of claims received were considered.

Medicaid Outreach

Q: What is the minimum expectation for providing Medicaid Outreach?

A: Each state-funded clinical health center must provide some level of Medicaid outreach in each of the five outreach areas each fiscal year. Each non-clinical center must provide some level of Medicaid outreach in areas 1, 2 and 5 each fiscal year. MDCH is currently finalizing a proposal to impose financial penalties to any center that consistently reports little or no outreach activities. In this proposal, thresholds of acceptable activity will be outlined so a center can gauge whether their level of outreach activity is meeting acceptable standards.

Q: What happens if our center doesn't provide "enough" Medicaid outreach?

A: MDCH reviews the quarterly Medicaid outreach reports to determine if a good-faith effort is in place to provide Medicaid outreach activities. A formal review of outreach activities is also incorporated into the site review process.

If it is determined at any time during the fiscal year or during a site review that the level or documentation of Medicaid outreach activities is insufficient, MDCH will first try to work with the center to verify what type of outreach is occurring and to verify the tracking/documentation methods being used. Sometimes a center is providing acceptable Medicaid outreach activities but is not aware that the activities are eligible for inclusion in the Medicaid outreach report. Other times, problems in tracking mechanisms or poor documentation result in inaccurate reports that reflect falsely low levels of activity. MDCH will work with the center to correct these issues and then ask for periodic updates of activity.

MDCH is finalizing a proposal to impose financial penalties to any center that consistently reports little or no outreach activities.

Q: What is the difference between Medicaid Outreach area 1 and area 5?

A: Outreach area one includes general public awareness activities used to spread the word about Medicaid services and eligibility. Distribution of health center brochures and flyers, newsletters, direct mailings to families, and health fair participation where health center assistance with application and provision of Medicaid-covered services is presented, are

all examples of activities that qualify under this area. Additionally, if you are providing health education to students on any health topic and you incorporate a brief overview of Medicaid eligibility, application and an explanation of Medicaid-covered services offered by the center into a presentation, you would count and report the number of participants in this area. Count and report the number of individuals reached, pieces of literature provided, circulation of the newsletter, number of letters mailed and the like in this outreach area.

Outreach area five is targeted training specific to Medicaid topics such as eligibility, the application process and service provision. These include trainings on "Medicaid only topics" that your health center provides. It also includes trainings that your health center staff participates in to learn more about Medicaid eligibility requirements, to assist clients with the application process, and to improve assistance in the application process. In this outreach area, you report two numbers - the number of trainings attended or provided as well as the number of participants.

For these two outreach areas only, activity that you provide adults is also included in the count of persons reached.

Q: How is the Medicaid Outreach reporting data used?

A: Medicaid outreach reporting data is compiled into a database on a quarterly basis. The data that your individual center reports is provided quarterly to the Medicaid Health Plans and to the Center for Medicaid Services. This data is presented by health center, so a health plan, CMS staff and other interested parties are aware of the level of outreach activity provided by each individual center in each of the five outreach areas and in MHP billing, for each of the ten Medicaid regions across the state.

Site Reviews

Q: What happens if my center doesn't do well on a site review? Are financial penalties attached to the reviews?

A: If your center does not perform well in a site review, a follow-up site review will be scheduled within three to six months of the original review. At that time, progress will be re-assessed and further action taken based on the number and severity of outstanding citations. Financial penalties could be imposed if improvement has not occurred by this second follow-up site review.

MDCH is considering a proposal to grant centers various levels of accreditation status based on the review findings (similar to the local health department accreditation process). These results would be available to the public.